Reset

Standard Insurance Company
920 SW Sixth Avenue Portland OR 97204-1203 866.440.4846

State of Arizona
Employer Statement for Group Life Portability Insurance

This form is to be completed by Employer. Complete entire form and mail to the address above.

1. MEMBER INFORMATION

Full Name:		Sex: ☐ Male ☐ Female
Social Security Number:	Birthdate:	Occupation:

2. EMPLOYER INFORMATION

Group Name: **State of Arizona**	Employer Name: (if different)
Group No.: **617950**	Effective date of Employer's coverage under the Group Policy:

Is the Member's Group Life Insurance ending because of employment termination? ☐ Yes ☐ No

If yes, date of employment termination: Date coverage ends:

Date Member last worked:

If no, reason for termination of Member's Group Life Insurance:

Is employment terminating due to medical reasons? ☐ Yes ☐ No

Original effective date of Member's coverage:

3. AMOUNT OF INSURANCE

	GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE	AD&D INSURANCE (if applicable)
Member:	$	$
Spouse:	$	
Children:	$	

4. EMPLOYER AUTHORIZATION

I hereby represent that the above information is true and complete to the best of my knowledge.

Signature of Authorized Representative:	Date:
Name and Title: (please print or type)	
Address:	Telephone No.:

Print and Sign